PRINTED: 11/05/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAL ERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 297124 07/25/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2780 S JONES STE B **FAMILY CARE HOME HEALTH AGENCY** LAS VEGAS, NV 89146 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) G 000 | INITIAL COMMENTS G 000 The agency does not dispute the findings of the survey team. The deficient practices This Statement of deficiencies was generated as identified by the survey team and stated in a result of the Medicare recertification survey this Statement of Deficiencies had previously been identified by the Quality conducted at your agency on July 24 through July Assurance/Performance Improvement 25, 2008. Department. This is evidenced by the quarterly clinical record reviews for 3rd & The findings and conclusions of any investigation 4th quarter 2007, 1st & 2nd quarters of 2008 by the Health Division shall not be construed as and the annual program evaluation. This prohibiting any criminal or civil investigations. documentation was reviewed by the survey actions or other claims for relief that may be team at the time of the survey. Plans of available to any party under applicable federal. state, or local laws. action related to these deficiencies were instituted immediately after the conclusion of the survey and will continue to be areas The active census at the time of the survey was of focus for 3rd & 4th quarters 2008. 16 clinical records were reviewed 4 home visits were conducted. The following complaint was investigated and found to be unsubstantiated. CPT #NV18548- unsubstantiated The following regulatory deficiencies were identified: G 158 484.18 ACCEPTANCE OF PATIENTS, POC, G 158 G 158 Corrective action for patients affected by the MED SUPER deficient practice. The agency is unable to correct the deficient Care follows a written plan of care established

patients in the sample (#4, #6, #11, #13, #14).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on interview and record review, the agency failed to ensure the care followed a written plan of

This STANDARD is not met as evidenced by:

care established by the physician for 5 of 16

and periodically reviewed by a doctor of medicine,

osteopathy, or podiatric medicine.

TITLE

practice for Patients #4, #6, #11, #14 as these patients have been discharged from the

Patient #13 - Visits were conducted the

week as per the plan of care for the weeks 2008 beginning 6/29/08 and 7/8/08. (Attachment

BUREAU OF LICENSURE AND CERTIFICATION

LAS VEGAS, NEVADA

ADMINISTRATOR

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

agency.

M1)

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAIL RVICES				FORM	: 11/05/2008 APPROVED . 0938-0391
STATEMENT AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	LDIN	PLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		297124	B. WIN	IG_			5/2008
NAME OF P	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	0112	3/2000
FAMILY	CARE HOME HEALTH	1 AGENCY		2	780 S JONES STE B AS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 158	Continued From pa	ge 1	G 1	58	Other patients having the potential t	o be	<u> </u>
	Findings include:				affected by The deficient practice. All patients have the potential to be affected		
	Patient #4				by this deficient practice.		
	following diagnoses Hypertension, and F Record Review 1. The start of care, stated: "SN (skilled day for 60 days. SN related to diabetes revery visit, signs and hyperglycemia, know and compliance to opatient/ caregiver's a				Measures or systemic changes instite ensure the deficient practice will not All staff have received in depth inseducation, 1:1 counseling, copies of nurse practice act and newsletters addressing adherence to of care, (Attachment M-2) The RN's received instruction regarding completion of the initial assessment. The assessment must be plan of care that reflects the actual needs of the patient and not a textbook plan of care related to the process. (Attachment M-3)	recur. ervice the the plan s have ad to a disease	
	evidence to verify the home visits as order. 3. During 7/14/08 the documented evidence conducted two home physician. Interview On 7/24/08, the Direct agency staff were direct.	rough 7/20/08, there was no ce to verify the skilled nurse e visits as ordered by the ector of Nursing revealed rected to have the skilled		1, 2016	every Friday. The DPS (Director of Professional Services) will review the schedules to ensure that a frequency matches the plan of care. disciplines are to submit visit notes every Monday. Medical a staff will input documentation into a track. Medical records will notice the administrator or DPS of a discrepancies or missing notes week DPS will follow-up with the appropriate discipline to envisit notes are submitted timely.	the visit All records visit ny visit	
	the next week. The a	the office on the Monday of agency was unable to provide vere conducted as per the		# A4 V W W	The QA/PI (Quality Assurance/Perf Improvement) Department will revie	ew all	Pro-Body - Have to A statute

physician's orders.

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Improvement) Department will review all notes and compare the documentation to the

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	TMENT OF HEALTH	I AND HUMAN SERVICES			FORM): 11/05/2008 APPROVED): 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S	SURVEY
		297124	B. WING		07/	C 2 5/2008
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 2780 S JONES STE B LAS VEGAS, NV 89146	0112	23/2006
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 158	following diagnoses Heart Failure, Fract of Gait and Alzheim Record Review On 6/16/08, the phy has redness at the cleansed using ase saline, pat dry, appl with dry sterile dress. On 6/25/08 and 6/2	mitted on 6/3/08 with the Hypertension, Congestive ure of Distal Ulna, Abnormality er's Disease. Sician's order stated: "Patient coccyx area. Skilled Nurse ptic technique with normal y zinc oxide ointment, coversing, secure with tape."	G 158	patient's plan of care/physician's orders. The QAIPI department will also ensure the clinical record contains physician's orders have been obtained for all treatments administered. Monitoring of corrective action. The QA/PI department will continue to monitor all clinical notes for adherence to the plan of care. In-service education and 1:1 counseling will continue.		
	apply Siver (Silver?) sterile dressing and licensed nurse failed treatment administe physician's order. Patient #11 The patient was adr following diagnoses Abnormality of Gait, Hypertension and Community of Record Review	se with normal saline, pat dry, 9 Sulfa 1% cover with dry secure with tape." The dot to ensure the wound red to the patient followed the nitted on 6/4/08 with the Dizziness and Giddiness, Diabetes Mellitus, oronary Atherosclerosis.		compliance While the QA/PI Department will primary responsibility for monitori adherence to the plan of care, The DPS will have ultimate responsibil ensure all staff provide care in account the plan of care. Date of completion 12/2 /08	ng ity to	

week for 2 weeks; 2 times a week for 2 weeks

On 7/25/08, the weekly nursing home visits ordered by the physician were not available for

and 1 time a week for 5 weeks."

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		AND HUMAN SERVICES): 11/05/2008 MAPPROVED
•	RS FOR MEDICARE				()	OMB NO	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) J A. BU		TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	ETED
		297124	B. WI	NG_		07/:	C 2 5/2008
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD		
FAMILY	CARE HOME HEALTH	AGENCY		1	2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX ·	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 158	Continued From pa	ge 3		158			
	1	through the week ending	J	100			
	Patient #13						
	following diagnoses Reduction Femur, C	mitted on 11/12/07 with the : Malaise and Fatigue, Open Distructive Chronic Bronchitis, Diabetes Mellitus and					
Ì	Record Review						
	7/8/08, stated: "SN (times a week for 4 v weeks; CNA (certific a week for 4 weeks; for personal care/ hy	rder dated 5/10/08 through (skilled nurse) frequency: 2 veeks; 1 time a week for 5 ed nursing aide) order: 2 times 1 time a week for 5 weeks /giene, activities of daily living or assigned tasks as per h aide standard."					
	weeks beginning 5/2	three home visits during the 25/08, 6/1/08 and 6/8/08, not ordered by the physician.					
	weeks beginning 6/1	two home visits during the 15/08, 6/22/08 and 6/29/08, s ordered by the physician.					
	The licensed nurse of during the week beg ordered by the physical properties of the physical propertie	conducted an extra home visit inning 6/8/08, not one as ician.					
	nurse conducted hor	nented evidence the licensed me visits during the weeks rough the end of the					

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		AND HUMAN SERVICES					11/05/2008 APPROVED
	RS FOR MEDICARE						0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
		297124	B. WI	NG.		i e	C 5/2008
NAME OF F	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	0.17	0,2000
FAMILY	CARE HOME HEALTI	H AGENCY			2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICE OF THE APP	JLD BE	(X5) COMPLETION DATE
G 158	Continued From pa	age 4	G	151	8		
	2. The physician's of 9/6/08, stated: "SN	order dated 7/9/08 through (skilled nurse) frequency: 2 weeks; 1 time a week for 6	G	100			
	licensed nurse cond	mented evidence to verify the ducted two home visits during of the recertification period					
i	Patient #14						
ļ	following diagnoses Malaise and Fatigue	mitted on 7/12/08 with the s: Coronary Artery Disease, e, Long-term Use ertension and Gouty					
	9/9/08, stated: "SN time a week for 1 w weeks, 2 times a we week for 3 weeks. S assess incision site angiogram, observed drainage, signs and	er dated 7/12/08 through (skilled nurse) frequency: 1 eek, 3 times a week for 2 eek for 3 weeks; 1 time a Skilled assessment: SN to on left groin status post of for increased bruising, any symptoms of infection, ed extremity, pain status."					
	conducted home vis documented skin in	7/08, the licensed nurse sits. The skilled nurse tact. The section for ncision and bruises were not killed nurse.					
	licensed nurse asse groin status post an	mented evidence to verify the essed the incision site on left giogram, observed for any drainage, signs and			1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		

symptoms of infection, and sensation on affected

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAIL RVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297124	B. WING		C 07/25/2008	
	ROVIDER OR SUPPLIER	H AGENCY	2	REET ADDRESS, CITY, STATE, ZIP CODE 780 S JONES STE B .AS VEGAS, NV 89146	y 01123120	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
G 158	Continued From pa	ge 5	G 158			
G 159	The plan of care de the agency staff co-including mental sta equipment required prognosis, rehabilitalimitations, activities requirements, medisafety measures to	eveloped in consultation with vers all pertinent diagnoses, atus, types of services and pertinent, frequency of visits, ation potential, functional sepermitted, nutritional cations and treatments, any protect against injury, and discharge or referral, and	G 159	G 159 Corrective action for patients affect deficient practice. Patient #13 - See (Attachment M-4 regarding the current status of the potential affected by the deficient practice. All patients have the potential to be by this deficient practice.) patient.	
	Based on interview care failed to includ discharge for 1 of 1 Findings include: Patient #13 The patient was add following diagnoses	s not met as evidenced by: and record review, the plan of e instructions for timely		Measures or systemic changes institensure the deficient practice will not Case conferences are conducted we Staff has been instructed that dischaplanning must begin at the time of the initial assessment. Staff provide a skilled service to the patieach visit and will document the patient's progress towards goals measurable terms. The RN will assepatient and in consultation with the physician, determine if ski services are to continue (See 164).	ot recur. bekly. arge must ent at s in ess the	
The state of the s	Abnormality of Gait, Hypertension. Record Review Patient #13 had rec since 11/12/07. 1. The Plan of Care dated 5/10/08 throu nurse) frequency: 2	postructive Chronic Bronchitis, Diabetes Meilitus and eived home health services for the recertification period, gh 7/8/08 stated: "SN (skilled times a week for 4 weeks; 1 eeks; CNA (certified nursing		Documentation in clinical notes mureflect the skilled service provided determination of continuation of cabe based on this documentation, not just the verbal at the staff. When skilled services are longer required, the patient must be discharged from the agency Monitoring of corrective action. The QA/PI department will review notes to ascertain if clinical notes state the need for skilled	and re shall report of no y.	

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	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAIL RVICES			FORM): 11/05/2008 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE S	
		297124	B. WING		07/:	C 25/2008
	ROVIDER OR SUPPLIER CARE HOME HEALTI	H AGENCY		REET ADDRESS, CITY, STATE, ZIP CO 2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 159	aide) order: 2 times week for 5 weeks for 6 activities of daily living assigned tasks as pstandard." The 60 day summan stated "Patient contrespiratory status worderate to maxim daily living, dependent and night; Patient is uses walker occasion with assistance and and potential disease. 2. The physician's of 9/6/08, stated: "SN times a week for 3 weeks. CNA (certification a week for 4 weeks. The 60 day summan stated "Patient contrespiratory of falling reconneed moderate to maximal factivities of daily living the day and reconstruction."	a week for 4 weeks; 1 time a presonal care/ hygiene, and assistance and other per certified home health aide by for the recertification period inues to have altered ith poor endurance, needs um assist with activities of ent on oxygen during the day mainly wheelchair bound, anally to go to the bathroom supervision, high risk for falls sees complications." Inder dated 7/9/08 through (skilled nurse) frequency: 2 weeks; 1 time a week for 6 end nurse aide) order: 2 times in 1 time a week for 5 weeks." Ty for the recertification period inues to have generalized end respiratory status with a cently; patient continues to naximum assist with ADL's ing), dependent on oxygen hight; Patient is mainly elderly spouse; continues to be	G 159		dentified ntative will provide this ing PS will have nitoring nd discharge inistrator will	
	During a home visit the spouse indicated	on 7/25/08, the patient and dithe home health staff had not for discharge from home the start of care.				

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		AND HUMAN SERVICES			FORM	: 11/05/2008 APPROVED
	RS FOR MEDICARE				OMB NO	<u>. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	DING	(X3) DATE S COMPLI	ETED
		297124	B. WING	<u> </u>		C 2 5/2008
NAME OF F	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO		.0,200
FAMILY	CARE HOME HEALTH	1 AGENCY		2780 S JONES STE B LAS VEGAS, NV 89146	<i>7</i> 02	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 164	Agency professional physician to any character the plan of care. This STANDARD is	C REVIEW OF PLAN OF Il staff promptly alert the anges that suggest a need to e. Is not met as evidenced by: view, the agency staff failed to	G 16	Corrective action for patients of deficient practice. The agency is unable to correct practice for Patient #2 as the pubeen discharged from the agency.	et the deficient atient has	
	alert the physician to condition which sug plan of care for 1 of	o changes in the patient's gested a need to alter the 16 sampled patients (#2).		Other patients having the potential affected by the deficient practical All patients have the potential by this deficient practice.	ce.	
	2/21/08. The diagno	year old female admitted on uses were Chronic Kidney uiabetes Mellitus, Coronary Hypertension.		Measures or systemic changes ensure the deficient practice w Staff was in-serviced regarding Nurse Practice Act and Medica requirements. Staff was instru providing any treatments or ca physician's order was practicin their scope of practice a violati	vill not recur. g the Nevada are regulatory cted that re without a ng outside	
	(skilled nurse) frequiveeks; 1 time a weeks; 1 time a weeks; 1 time a weeks; 1 time a weeks; 10 to temperature over 10 (systolic blood pressimmly (millimeters ander 60 mg/dl and /adverse response to Early signs and syminjury."	lated 2/21/08, stated: "SN ency: 2 times a week for 2 ek for 7 weeks. Skilled notify MD (doctor) for 01 degrees Fahrenheit; SBP sure under 90 and over 160 mercury); BS (blood sugar over 250mg/dl; No response o medications and treatment; eptoms of infection; fall /		Nurse Practice Act and the reg requirements. Staff was also instructed that P to be notified of any changes in vital signs below parameters, b results outside of stated paramin wound status, cognitive state ambulation. All contacts with t are to be documented by the percontacting the physician. Documentation is to be specificated by the percontacting the physician.	Physician's are n condition, plood sugar eters, changes us or the physician erson	
i		nsed nurse documented:		also to be documented. If staff		

occurrence with hypoglycemia. Mostly

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leaves a message and does not receive a

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		AND HUMAN SERVICES): 11/05/2008 I APPROVED
CENTE	RS FOR MEDICARE			(_)		0.0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPL	
		297124	B. WIN	G	 . _{07/2}	C 25/2008
	PROVIDER OR SUPPLIER CARE HOME HEALTH	H AGENCY		STREET ADDRESS, CITY, STATE, Z 2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
G 164	(unable to read	d) episode during early d sugars between 40-49 on	G 1	Return call from the physimember wilt follow-up wi (Attachment M-2)	cian, the staff th the next day.	-
	On 3/20/08, the licensed nurse documented: "Patient reported hypoglycemia at 1200 midnight with blood sugar read 64 went to drink purple juice at this time blood sugar 163."			As this requirement coinci and GI 59, please see correctives these tags. Monitoring of corrective a	ective action at	
	hospital. A physiciar care was initiated or	ient was transferred to a local n's order for resumption of n 4/3/08. The physician's indicated the patient was now		All clinical notes will be re QA/PI department to ensu- notified the physician of a changes in the patient's co-	eviewed by the re staff has ny ndition.	
	The record lacked diskilled nurse alerted	documented evidence the difference the physician regarding the pisodes reported by the		Responsible Party for mon compliance The DPS will be ultimately ensure compliance	•	
G 165		RMANCE WITH PHYSICIAN	G 16	Date of completion 12/2 /08		
i	Drugs and treatmen agency staff only as	nts are administered by ordered by the physician.		G 165 Corrective action for patie deficient practice. The agency is unable to co		
	Based on interview staff failed to admini	s not met as evidenced by: and record review, agency ister drugs and treatments		practice for Patients #1, #2 patients have been discharged from the agence	2, #6, #16 as these	
	sampled patients (#	he physician for 4 of 16 #1, #2, #6, #16).		Other patients having the affected by the deficient pr All patients have the poten	ractice.	
	Findings include: Patient #1			by this deficient practice. Measures or systemic char ensure the deficient practic	nges instituted to	
		7 year old male admitted		Staff was in-serviced regard Nurse Practice Act and Me	rding the Nevada	

9/4/07. The diagnoses were Abnormality of Gait,

Alzheimer's Disease, Open Wound of Elbow, and

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providing any treatments

requirements. . Staff was instructed that

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PRINTED: 11/05/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAL OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 297124 07/25/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2780 S JONES STE B **FAMILY CARE HOME HEALTH AGENCY** LAS VEGAS, NV 89146 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) G 165 Continued From page 9 G 165 or care without a physician's order was Lumbago. practicing outside their scope of practice a violation of the Nurse Record Review Practice Act and the regulatory requirements. On 9/4/07, the licensed nurse documented: "a skin tear located on the left elbow measured 4 cm When the patient requires therapy services, (centimeters) by 0.5 cm by 0." The licensed the admitting RN will obtain a physician's nurse documented: "wound cleansed with soap order for an evaluation and water and apply Neosporin ointment and by the therapist. The DPS will ensure a cover with dry 4x4 and tape daily." The family physician's order has been written and will returned demonstration for the treatment of the give report to the therapist wound satisfactory. including but not limited to, diagnosis, demographic information, ordering The record lacked documented evidence a physician and treatment required. physician's order was obtained for wound care. The DPS will ascertain from the therapist the date and approximate time the therapist Patient #2 will conduct the initial Patient #2 was a 78 year old female admitted 2/21/08. The diagnoses were Chronic Kidney Disease, Anemia, Diabetes Mellitus, Coronary evaluation, ensuring that the evaluation will Atherosclerosis and Hypertension. be conducted within 72 hours of the start of care. This information Record Review will be documented on the therapy referral

The plan of treatment dated 2/21/08, listed the following medications: "Glimepiride 2mg. (milligrams) one tablet by mouth two time a day." The patient was on a no concentrated sugar, low fat, low salt, low cholesterol diet.

On 3/27/08, the patient was transferred to a local hospital. A physician's order for resumption of care was initiated on 4/3/08. The physician's order dated 4/3/08, indicated: "the patient was now on insulin injections and an 1800 calorie ADA (American Diabetic Association), low salt. low fat, and low cholesterol diet."

Monitoring of corrective action.

The OA/PI department will cont

The QA/PI department will continue to monitor all clinical notes for adherence to the plan of care and appropriate physician's orders for any new/changed medications or treatments. Inservice education and 1:1 counseling will continue.

These corrective actions are in conjunction

with the corrective actions identified at @158

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and **Q**164,

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DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES					D: 11/05/2008
CENTE	RS FOR MEDICARE	& MEDICAL ERVICES					И APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A. BUILI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297124	B. WING	3_		07/	C 25/2008
	ROVIDER OR SUPPLIER CARE HOME HEALTH	I AGENCY	,	2	REET ADDRESS, CITY, STATE, ZIP CODE 1780 S JONES STE B LAS VEGAS, NV 89146		23/2006
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	"Patient given teach giving Insulin injecti disposal." On 4/10/08, the lice "Lantus 10 units ever that may result hyposymptoms cold clan lethargic effect." The evidence a physicia obtained. Patient #6 The patient was adrifollowing diagnoses Heart Failure, Fracti Gait and Alzheimer's Record Review The physician's orde 8/12/08, indicated: "evaluation." There was no docur occupational therapi evaluation as ordere Interview On 7/24/08, the Direverify an OT evaluation Patient #16	sed nurse documented: hing on proper technique of on and also proper sharp Insed nurse documented: hery morning. New medication hoglycemia reaction; signs and homy sweat, lightheadedness here record lacked documented his order for Insulin was Initted on 6/3/08 with the hit Hypertension, Congestive here Distal Ulna, Abnormality of his Disease. Here dated 6/3/08 through hot (Occupational Therapy) Innented evidence to verify the hist conducted an OT here by the physician.	G 16	35	Responsible Party for monitoring compliance The QA/PI Department will have responsibility for monitoring adhethis action plan. The DPS will have responsibility to ensure this regular requirement is met Date of completion 12/2 /08	primary erence to ve ultimate	
1	The patient was adn	niced on 6/13/08 with the		- 1			į.

following diagnoses Drug Dependency, Anxiety

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	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES EN MEDICAL ERVICES			FORM A	11/05/2008 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		297124	B. WING _		07/25	5/2008
	PROVIDER OR SUPPLIER CARE HOME HEALTH	AGENCY] :	REET ADDRESS, CITY, STATE, ZIP CODE 2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 165	State, Schizophreni Hypertension. Record Review The physician's ord 8/11/08, stated: "Sk a week for 4 weeks On 6/18/08, the phy physical therapy evarecommendation to week for 5 weeks. To conducted a physician's order. Interview On 6/25/08, the Dire physicians's order for evaluation. 484.30(a) DUTIES (NURSE) The registered nursing need to re-evaluate for 1 of 16 sampled.	er dated 6/13/08 through illed Nurse frequency 2 times; 1 times a week for 6 weeks." sical therapist conducted a aluation with a treat the patient 2 times a The physical therapist all therapy evaluation without a property of Nursing did not find a property of the physical therapy. OF THE REGISTERED The regularly re-evaluates the eds. The patient's nursing needs	G 165	G 172 Corrective action for patients affect deficient practice. The agency is unable to correct the practice for Patients #1 this patient I discharged from the agency. Other patients having the potential affected by the deficient practice. All patients have the potential to be by this deficient practice.	deficient has been to be affected	
	Patient #1 was an 8	7 year old male admitted		Measures or systemic changes instit ensure the deficient practice will no As this deficient practice coincides	t recur.	:

Patient #1 was an 87 year old male admitted 9/4/07. The diagnoses were Abnormality of Gait,

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deficient practices identified at G 158, G 159, G 164, and G 165, the corrective action

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				_	: 11/05/2008
	RS FOR MEDICARE						APPROVED . 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	SURVEY ETED
		297124	B. WIN	NG_			C
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	0712	25/2008
FAMILY	CARE HOME HEALTH	HAGENCY		:	2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 172	Continued From pa	ge 12	G 1	 172		•	
	Alzheimer's Disease Lumbago. Record Review The physician's order	e, Open Wound of Elbow, and er dated 9/4/07, stated:" SN tency 2 times a week for 2	G	112	at those tags will also apply to G 12 has been instructed that even when members assume care of the wound nurse is still responsible for assessi status of the wound at each visit and notifying the physician of changes that may necessitate a chartreatment plan.	family l, the ng the any	
	skin tear located on (centimeters) by .5 of documented: "woun water and apply Neo with dry 4x4 and tap	sed nurse documented: "a the left elbow measured 4 cm cm by 0." The licensed nurse d cleansed with soap and esporin ointment and cover be daily." The family returned the treatment of the wound			Monitoring of corrective action. The QA/PI staff will review all clin notes to ensure staff has assessed at changes to the patient's wounds or other changes in condition. Responsible Party for monitoring compliance	ny	
İ	On 9/10/07 and 9/14/07, the licensed nurse indicated the wound located on the left elbow was healing and the treatment was done by the spouse. On 9/28/07, the patient was transferred to an assisted living facility. On 10/10/07, the licensed nurse indicated the patient had decreased mobility and refused to ambulate.				The QA/PI Department will have p responsibility for monitoring adher this action plan. The DPS will have ultimate responsibility to this regulatory requirement is met Date of completion 12/2 \$\sqrt{08}\$	ence to	
G 229	patient had a decub heel which measure cm by 0.1 cm with a		G 2	229			
	described in paragra	e (or another professional aph (d)(1) of this section) te visit to the patient's home an every 2 weeks.			G229 Corrective action for patients affect deficient practice. Home Health Aide supervisory visibeen conducted	•	

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	TMENT OF HEALTH	I AND HUMAN SERVICES				FORM): 11/05/2008 1 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		297124	B. WIN	4G _		07/	C 2 5/2008
	PROVIDER OR SUPPLIER CARE HOME HEALTH	1 AGENCY	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2780 S JONES STE B LAS VEGAS, NV 89146		23/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 229	Continued From pa	ge 13	G 2	229		-	7
	Based on record re- ensure supervisory	s not met as evidenced by: view, the agency failed to visits of the home health ed every 14 days for 1 (3)			every two weeks since the survey #13.(Attachment M-6) Other patients ha ping the potentia affected by the deficient practice. All patients have the potential to b by this deficient practice.	l to be	
	Patient #13 The patient was admitted on 11/12/07 with the following diagnoses: Malaise and Fatigue, Open Reduction Femur, Obstructive Chronic Bronchitis, Abnormality of Gait, Diabetes Mellitus and Hypertension. Record Review The physician's order dated 5/10/08 through 7/8/08, stated: "CNA (certified nursing aide/home health aide) order: 2 times a week for 4 weeks; 1 time a week for 5 weeks for personal care/hygiene, activities of daily living assistance and other assigned tasks as per certified home health aide standard."				Measures or systemic changes instensure the deficient practice will not a supervise the home health aide as stated in the Nurse Fact. When patients are receiving the services of a home health aide the case managers will identify on weekly schedule when supervisory to be conducted. Medical records staff will input documentativisit track. Medical records will not administrator or DPS of any visit discrepancies or missing supervisory visits weekly. (SEE ATTACHED)	ot recur. een rectice rectice their visits are	
G 337	conducted on 5/26/0 evidence to verify the skilled nur supervisory visit no weeks. 484.55(c) DRUG RE The comprehensive review of all medicar	d supervisory visit was 28. There was no documented se conducted on-site less frequently than every 2 EGIMEN REVIEW assessment must include a tions the patient is currently intify any potential adverse	G 3	337	G 337 Corrective action for patients affect deficient practice. Patient #4 and Patient #13 are the cactive patients currently receiving	only	

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		AND HUMAN SERVICES): 11/05/2008 1 APPROVED
	RS FOR MEDICARE						0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		297124	B. WI	B. WING		O7/25/2008	
NAME OF P	ROVIDER OR SUPPLIER		•	STE	REET ADDRESS, CITY, STATE, ZIP CODE		.012000
FAMILY	CARE HOME HEALTH				2780 S JONES STE B LAS VEGAS, NV 89146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 337			G;	 337			
	effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure comprehensive assessments included a review of all medications patients were currently using in order to identify any potential adverse effects and drug reactions for 16 of 16 patients in the sample (#1 through #16).			a na siste	by the agency. The remaining patients identified on the roster have been discharge. The agency has instituted a new medication profile and medication side effects/instruction guide (Attachment Other patients having the potential to be affected by the deficient practice. All patients have the potential to be affected by this deficient practice.		
	Findings include: Record Review Patients #1 through #16				Measures or systemic changes insti ensure the deficient practice will no The new medication profile specific	ot recur.	
					identifies if duplicate/ineffective dr therapies or potential	· ·	
	The Medication Profile located in the patients' records, listed the current medications the patients were taking. There was no documented evidence to verify the comprehensive assessment included a review of all medications the patients were currently using norder to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. On 7/25/08, the Quality Assurance registered nurse had identified these findings.				contraindications as well as an area identif5' potential side effects of the medication. The agency will supplement this form with a four (4 medication side effects/instruction (Attachment M-5). A copy of the medication profile and the in guide will remain in the patient's homedication profile will be reviewed at each visit and u when new medications are added o medications are changed. The medication instruction sheet will be personalized for each patient by cirhighlighting the appropriate (SEE ATTACHED)	e i) page guide struction ome. The pdate r	
				1	,		1

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DEPAR	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SERVICES): 11/05/2008 1 APPROVED
		OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	ETED
297124			B. WING	S	C 07/25/2008	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		23/2006
FAMILY	CARE HOME HEALTH	H AGENCY		İ		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 337	Continued From page 14		G 337		<u></u>	
	effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure comprehensive assessments included a review of all medications patients were currently using in order to identify any potential adverse effects and drug reactions for 16 of 16 patients in the sample (#1 through #16). Findings include: Record Review Patients #1 through #16 The Medication Profile located in the patients' records, listed the current medications the patients were taking. There was no documented evidence to verify the comprehensive assessment included a review of all medications the patients were currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.			by the agency. The remaining patients identified on the roster have been discharge. The agency has instituted a new medication profile and medication side effects/instruction guide (Attachment		
				Other patients having the pote affected by the deficient practi All patients have the potential by this deficient practice.	ice.	
				Measures or systemic changes ensure the deficient practice w The new medication profile sp	ill not recur.	
				identifies if duplicate/ineffecti therapies or potential	ve drug	
				contraindications as well as an identif5' potential side effects medication. The agency will supplement this form with a formalisation side of the state of the s	of the our (4) page	- To To To To To To To To To To To To To
				medication side effects/instruction guide (Attachment M-5). A copy of the medication profile and the instruction guide will remain in the patient's home. The medication profile will be reviewed at each visit and update when new medications are added or medications are changed. The medication instruction sheet will be		
	Interview			personalized for each patient b highlighting the appropriate	y circling or	
	On 7/25/08, the Qua nurse had identified	lity Assurance registered these findings.		(SEE ATTACHED)		

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